

Introduced by Senator PanFebruary 19, 2019

An act to amend Sections 1385.03, 1385.045, 1385.07, 128735, 128740, and 128760 of the Health and Safety Code, and Section 10181.45 of the Insurance Code, relating to healthcare.

LEGISLATIVE COUNSEL'S DIGEST

SB 343, as introduced, Pan. Healthcare data disclosure.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan or health insurer in the individual, small group, or large group markets to file rate information with the appropriate department, but specifies alternative information to be filed by a health care service plan or health insurer that exclusively contracts with no more than 2 medical groups.

Existing law establishes the Office of Statewide Health Planning and Development (OSHPD) in the California Health and Human Services Agency to regulate health planning and research development. Existing law generally requires a healthcare facility to report specified data to OSHPD, but requires OSHPD to establish specific reporting provisions for a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans. Existing law authorizes hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis, and exempts hospitals authorized to report as a group from reporting revenue separately for each revenue center.

This bill would eliminate alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups or a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and would instead require those entities to report information consistent with any other health care service plan, health insurer, or health facility, as appropriate. The bill would also eliminate the authorization for hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
 State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1385.03 of the Health and Safety Code
- 2 is amended to read:
- 3 1385.03. (a) ~~AA~~ health care service ~~plans~~ *plan* shall file with
- 4 the department all required rate information for grandfathered
- 5 individual and grandfathered and nongrandfathered small group
- 6 health care service plan contracts at least 120 days prior to
- 7 implementing ~~any~~ a rate change. ~~AA~~ health care service ~~plans~~
- 8 *plan* shall file with the department all required rate information
- 9 for nongrandfathered individual health care service plan contracts
- 10 on the earlier of the following dates:
- 11 (1) One hundred days before October 15 of the preceding policy
- 12 year.
- 13 (2) The date specified in the federal guidance issued pursuant
- 14 to Section 154.220(b) of Title 45 of the Code of Federal
- 15 Regulations.
- 16 (b) A plan shall disclose to the department all of the following
- 17 for each individual and small group rate filing:
- 18 (1) Company name and contact information.

- 1 (2) Number of plan contract forms covered by the filing.
- 2 (3) Plan contract form numbers covered by the filing.
- 3 (4) Product type, such as a preferred provider organization or
- 4 health maintenance organization.
- 5 (5) Segment type.
- 6 (6) Type of plan involved, such as for profit or not for profit.
- 7 (7) Whether the products are opened or closed.
- 8 (8) Enrollment in each plan contract and rating form.
- 9 (9) Enrollee months in each plan contract form.
- 10 (10) Annual rate.
- 11 (11) Total earned premiums in each plan contract form.
- 12 (12) Total incurred claims in each plan contract form.
- 13 (13) Average rate increase initially requested.
- 14 (14) Review category: initial filing for new product, filing for
- 15 existing product, or resubmission.
- 16 (15) Average rate of increase.
- 17 (16) Effective date of rate increase.
- 18 (17) Number of subscribers or enrollees affected by each plan
- 19 contract form.
- 20 (18) The plan's overall annual medical trend factor assumptions
- 21 in each rate filing for all benefits and by aggregate benefit category,
- 22 including hospital inpatient, hospital outpatient, physician services,
- 23 prescription drugs and other ancillary services, laboratory, and
- 24 radiology. A plan may provide aggregated additional data that
- 25 demonstrates or reasonably estimates year-to-year cost increases
- 26 in specific benefit categories in the geographic regions listed in
- 27 Sections 1357.512 and 1399.855. ~~A health plan that exclusively~~
- 28 ~~contracts with no more than two medical groups in the state to~~
- 29 ~~provide or arrange for professional medical services for the~~
- 30 ~~enrollees of the plan shall instead disclose the amount of its actual~~
- 31 ~~trend experience for the prior contract year by aggregate benefit~~
- 32 ~~category, using benefit categories that are, to the maximum extent~~
- 33 ~~possible, the same or similar to those used by other plans.~~
- 34 (19) The amount of the projected trend attributable to the use
- 35 of services, price inflation, or fees and risk for annual plan contract
- 36 trends by aggregate benefit category, such as hospital inpatient,
- 37 hospital outpatient, physician services, prescription drugs and other
- 38 ancillary services, laboratory, and radiology. ~~A health plan that~~
- 39 ~~exclusively contracts with no more than two medical groups in the~~
- 40 ~~state to provide or arrange for professional medical services for~~

1 ~~the enrollees of the plan shall instead disclose the amount of its~~
2 ~~actual trend experience for the prior contract year by aggregate~~
3 ~~benefit category, using benefit categories that are, to the maximum~~
4 ~~extent possible, the same or similar to those used by other plans.~~

5 (20) A comparison of claims cost and rate of changes over time.

6 (21) Any changes in enrollee cost sharing over the prior year
7 associated with the submitted rate filing.

8 (22) Any changes in enrollee benefits over the prior year
9 associated with the submitted rate filing.

10 (23) The certification described in subdivision (b) of Section
11 1385.06.

12 (24) Any changes in administrative costs.

13 (25) Any other information required for rate review under
14 ~~PPACA~~, *the federal Patient Protection and Affordable Care Act*
15 *(PPACA)*.

16 (c) A health care service plan subject to subdivision (a) shall
17 also disclose the following aggregate data for all rate filings
18 submitted under this section in the individual and small group
19 *health care service* plan markets:

20 (1) Number and percentage of rate filings reviewed by the
21 following:

22 (A) Plan year.

23 (B) Segment type.

24 (C) Product type.

25 (D) Number of subscribers.

26 (E) Number of covered lives affected.

27 (2) The plan's average rate increase by the following categories:

28 (A) Plan year.

29 (B) Segment type.

30 (C) Product type.

31 (3) Any cost containment and quality improvement efforts since
32 the plan's last rate filing for the same category of health benefit
33 plan. To the extent possible, the plan shall describe any significant
34 ~~new-health-care~~ *healthcare* cost containment and quality
35 improvement efforts and provide an estimate of potential savings
36 together with an estimated cost or savings for the projection period.

37 (d) The department may require all health care service plans to
38 submit all rate filings to the National Association of Insurance
39 Commissioners' System for Electronic Rate and Form Filing
40 (SERFF). Submission of the required rate filings to SERFF shall

1 be deemed to be filing with the department for purposes of
2 compliance with this section.

3 (e) A plan shall submit any other information required under
4 PPACA. A plan shall also submit any other information required
5 pursuant to any regulation adopted by the department to comply
6 with this article.

7 (f) (1) A plan shall respond to the department’s request for any
8 additional information necessary for the department to complete
9 its review of the plan’s rate filing for individual and small group
10 health care service plan contracts under this article within five
11 business days of the department’s request or as otherwise required
12 by the department.

13 (2) Except as provided in paragraph (3), the department shall
14 determine whether a plan’s rate increase for individual and small
15 group health care service plan contracts is unreasonable or not
16 justified no later than 60 days following receipt of all the
17 information the department requires to make its determination.

18 (3) For all nongrandfathered individual health care service plan
19 contracts, the department shall issue a determination that the plan’s
20 rate increase is unreasonable or not justified no later than 15 days
21 before October 15 of the preceding policy year. If a health care
22 service plan fails to provide all the information the department
23 requires in order for the department to make its determination, the
24 department may determine that a plan’s rate increase is
25 unreasonable or not justified.

26 (g) If the department determines that a plan’s rate increase for
27 individual or small group health care service plan contracts is
28 unreasonable or not justified consistent with this article, the health
29 care service plan shall provide notice of that determination to any
30 individual or small group applicant. The notice provided to an
31 individual applicant shall be consistent with the notice described
32 in subdivision (c) of Section 1389.25. The notice provided to a
33 small group applicant shall be consistent with the notice described
34 in subdivision (c) of Section 1374.21.

35 (h) For purposes of this section, “policy year” has the same
36 meaning as set forth in subdivision (g) of Section 1399.845.

37 SEC. 2. Section 1385.045 of the Health and Safety Code is
38 amended to read:

39 1385.045. (a) For large group health care service plan
40 contracts, ~~each~~ *a health care service* plan shall file with the

1 department the weighted average rate increase for all large group
2 benefit designs during the 12-month period ending January 1 of
3 the following calendar year. The average shall be weighted by the
4 number of enrollees in each large group benefit design in the plan's
5 large group market and adjusted to the most commonly sold large
6 group benefit design by enrollment during the 12-month period.
7 For the purposes of this section, the large group benefit design
8 includes, but is not limited to, benefits such as basic ~~health care~~
9 *healthcare* services and prescription drugs. The large group benefit
10 design shall not include cost sharing, including, but not limited to,
11 deductibles, copays, and coinsurance.

12 (b) (1) A plan shall also submit any other information required
13 pursuant to any regulation adopted by the department to comply
14 with this article.

15 (2) The department shall conduct an annual public meeting
16 regarding large group rates within four months of posting the
17 aggregate information described in this section in order to permit
18 a public discussion of the reasons for the changes in the rates,
19 benefits, and cost sharing in the large group market. The meeting
20 shall be held in either the Los Angeles area or the San Francisco
21 Bay area.

22 (c) A health care service plan subject to subdivision (a) shall
23 also disclose the following for the aggregate rate information for
24 the large group market submitted under this section:

25 (1) For rates effective during the 12-month period ending
26 January 1 of the following year, number and percentage of rate
27 changes reviewed by the following:

28 (A) Plan year.

29 (B) Segment type, including whether the rate is community
30 rated, in whole or in part.

31 (C) Product type.

32 (D) Number of enrollees.

33 (E) The number of products sold that have materially different
34 benefits, cost sharing, or other elements of benefit design.

35 (2) For rates effective during the 12-month period ending
36 January 1 of the following year, any factors affecting the base rate,
37 and the actuarial basis for those factors, including all of the
38 following:

39 (A) Geographic region.

40 (B) Age, including age rating factors.

1 (C) Occupation.

2 (D) Industry.

3 (E) Health status factors, including, but not limited to,
4 experience and utilization.

5 (F) Employee, and employee and dependents, including a
6 description of the family composition used.

7 (G) Enrollees' share of premiums.

8 (H) Enrollees' cost sharing, including cost sharing for
9 prescription drugs.

10 (I) Covered benefits in addition to basic ~~health care~~ *healthcare*
11 services, as defined in Section 1345, and other benefits mandated
12 under this article.

13 (J) Which market segment, if any, is fully experience rated and
14 which market segment, if any, is in part experience rated and in
15 part community rated.

16 (K) Any other factor that affects the rate that is not otherwise
17 specified.

18 (3) (A) The plan's overall annual medical trend factor
19 assumptions for all benefits and by aggregate benefit category,
20 including hospital inpatient, hospital outpatient, physician services,
21 prescription drugs and other ancillary services, laboratory, and
22 radiology for the applicable 12-month period ending January 1 of
23 the following year. ~~A health plan that exclusively contracts with
24 no more than two medical groups in the state to provide or arrange
25 for professional medical services for the enrollees of the plan shall
26 instead disclose the amount of its actual trend experience for the
27 prior contract year by aggregate benefit category, using benefit
28 categories, to the maximum extent possible, that are the same as,
29 or similar to, those used by other plans.~~

30 (B) The amount of the projected trend separately attributable
31 to the use of services, price inflation, and fees and risk for annual
32 plan contract trends by aggregate benefit category, including
33 hospital inpatient, hospital outpatient, physician services,
34 prescription drugs and other ancillary services, laboratory, and
35 radiology. ~~A health plan that exclusively contracts with no more
36 than two medical groups in the state to provide or arrange for
37 professional medical services for the enrollees of the plan shall
38 instead disclose the amount of its actual trend experience for the
39 prior contract year by aggregate benefit category, using benefit~~

1 categories that are, to the maximum extent possible, the same or
2 similar to those used by other plans.

3 (C) A comparison of the aggregate per enrollee per month costs
4 and rate of changes over the last five years for each of the
5 following:

6 (i) Premiums.

7 (ii) Claims costs, if any.

8 (iii) Administrative expenses.

9 (iv) Taxes and fees.

10 (D) Any changes in enrollee cost sharing over the prior year
11 associated with the submitted rate information, including both of
12 the following:

13 (i) Actual copays, coinsurance, deductibles, annual out of pocket
14 maximums, and any other cost sharing by the benefit categories
15 determined by the department.

16 (ii) Any aggregate changes in enrollee cost sharing over the
17 prior years as measured by the weighted average actuarial value,
18 weighted by the number of enrollees.

19 (E) Any changes in enrollee benefits over the prior year,
20 including a description of benefits added or eliminated, as well as
21 any aggregate changes, as measured as a percentage of the
22 aggregate claims costs, listed by the categories determined by the
23 department.

24 (F) Any cost containment and quality improvement efforts since
25 the plan's prior year's information pursuant to this section for the
26 same category of health benefit plan. To the extent possible, the
27 plan shall describe any significant new ~~health care~~ *healthcare* cost
28 containment and quality improvement efforts and provide an
29 estimate of potential savings together with an estimated cost or
30 savings for the projection period.

31 (G) The number of products covered by the information that
32 incurred the excise tax paid by the health *care service* plan.

33 (4) (A) For covered prescription generic drugs excluding
34 specialty generic drugs, prescription brand name drugs excluding
35 specialty drugs, and prescription brand name and generic specialty
36 drugs dispensed at a plan pharmacy, network pharmacy, or mail
37 order pharmacy for outpatient use, all of the following shall be
38 disclosed:

1 (i) The percentage of the premium attributable to prescription
2 drug costs for the prior year for each category of prescription drugs
3 as defined in this subparagraph.

4 (ii) The year-over-year increase, as a percentage, in per-member,
5 per-month total health *care service* plan spending for each category
6 of prescription drugs as defined in this subparagraph.

7 (iii) The year-over-year increase in per-member, per-month
8 costs for drug prices compared to other components of the ~~health~~
9 *care healthcare* premium.

10 (iv) The specialty tier formulary list.

11 (B) The plan shall include the percentage of the premium
12 attributable to prescription drugs administered in a doctor's office
13 that are covered under the medical benefit as separate from the
14 pharmacy benefit, if available.

15 (C) (i) The plan shall include information on its use of a
16 pharmacy benefit manager, if any, including which components
17 of the prescription drug coverage described in subparagraphs (A)
18 and (B) are managed by the pharmacy benefit manager.

19 (ii) The plan shall also include the name or names of the
20 pharmacy benefit manager, or managers if the plan uses more than
21 one.

22 (d) The information required pursuant to this section shall be
23 submitted to the department on or before October 1, 2018, and on
24 or before October 1 annually thereafter. Information submitted
25 pursuant to this section is subject to Section 1385.07.

26 (e) For the purposes of this section, a "specialty drug" is one
27 that exceeds the threshold for a specialty drug under the Medicare
28 Part D program (Medicare Prescription Drug, Improvement, and
29 Modernization Act of 2003 (Public Law 108-173)).

30 SEC. 3. Section 1385.07 of the Health and Safety Code is
31 amended to read:

32 1385.07. (a) Notwithstanding Chapter 3.5 (commencing with
33 Section 6250) of Division 7 of Title 1 of the Government Code,
34 all information submitted under this article shall be made publicly
35 available by the department except as provided in subdivision (b).

36 (b) (1) The contracted rates between a health care service plan
37 and a provider shall be deemed confidential information that shall
38 not be made public by the department and are exempt from
39 disclosure under the California Public Records Act (Chapter 3.5
40 (commencing with Section 6250) of Division 7 of Title 1 of the

1 Government Code). The contracted rates between a health care
2 service plan and a provider shall not be disclosed by a health care
3 service plan to a large group purchaser that receives information
4 pursuant to Section 1385.10.

5 (2) The contracted rates between a health care service plan and
6 a large group shall be deemed confidential information that shall
7 not be made public by the department and are exempt from
8 disclosure under the California Public Records Act (Chapter 3.5
9 (commencing with Section 6250) of Division 7 of Title 1 of the
10 Government Code). Information provided to a large group
11 purchaser pursuant to Section 1385.10 shall be deemed confidential
12 information that shall not be made public by the department and
13 shall be exempt from disclosure under the California Public
14 Records Act (Chapter 3.5 (commencing with Section 6250) of
15 Division 7 of Title 1 of the Government Code).

16 (c) All information submitted to the department under this article
17 shall be submitted electronically in order to facilitate review by
18 the department and the public.

19 (d) In addition, the department and the health care service plan
20 shall, at a minimum, make the following information readily
21 available to the public on their ~~Internet Web sites~~, *internet websites*
22 in plain language and in a manner and format specified by the
23 department, except as provided in subdivision (b). For individual
24 and small group health care service plan contracts, the information
25 shall be made public for 120 days prior to the implementation of
26 the rate increase. For large group health care service plan contracts,
27 the information shall be made public for 60 days prior to the
28 implementation of the rate increase. The information shall include:

29 (1) Justifications for any unreasonable rate increases, including
30 all information and supporting documentation as to why the rate
31 increase is justified.

32 (2) A plan's overall annual medical trend factor assumptions in
33 each rate filing for all benefits.

34 (3) A health *care service* plan's actual costs, by aggregate
35 benefit category to include hospital inpatient, hospital outpatient,
36 physician services, prescription drugs and other ancillary services,
37 laboratory, and radiology.

38 (4) The amount of the projected trend attributable to the use of
39 services, price inflation, or fees and risk for annual plan contract
40 trends by aggregate benefit category, such as hospital inpatient,

1 hospital outpatient, physician services, prescription drugs and other
2 ancillary services, laboratory, and radiology. ~~A health plan that~~
3 ~~exclusively contracts with no more than two medical groups in the~~
4 ~~state to provide or arrange for professional medical services for~~
5 ~~the enrollees of the plan shall instead disclose the amount of its~~
6 ~~actual trend experience for the prior contract year by aggregate~~
7 ~~benefit category, using benefit categories that are, to the maximum~~
8 ~~extent possible, the same or similar to those used by other plans.~~

9 SEC. 4. Section 128735 of the Health and Safety Code is
10 amended to read:

11 128735. An organization that operates, conducts, owns, or
12 maintains a health facility, and the officers thereof, shall make and
13 file with the office, at the times as the office shall require, all of
14 the following reports on forms specified by the office that ~~shall be~~
15 ~~are~~ in accord, if applicable, with the systems of accounting and
16 uniform reporting required by this part, except that the reports
17 required pursuant to subdivision (g) shall be limited to hospitals:

18 (a) A balance sheet detailing the assets, liabilities, and net worth
19 of the health facility at the end of its fiscal year.

20 (b) A statement of income, expenses, and operating surplus or
21 deficit for the annual fiscal period, and a statement of ancillary
22 utilization and patient census.

23 (c) A statement detailing patient revenue by payer, including,
24 but not limited to, Medicare, Medi-Cal, and other payers, and
25 ~~revenue center, except that hospitals authorized to report as a group~~
26 ~~pursuant to subdivision (d) of Section 128760 are not required to~~
27 ~~report revenue by revenue center.~~

28 (d) A statement of cashflows, including, but not limited to,
29 ongoing and new capital expenditures and depreciation.

30 (e) A statement reporting the information required in
31 subdivisions (a), (b), (c), and (d) for each separately licensed health
32 facility operated, conducted, or maintained by the reporting
33 ~~organization, except those hospitals authorized to report as a group~~
34 ~~pursuant to subdivision (d) of Section 128760.~~ *organization.*

35 (f) Data reporting requirements established by the office shall
36 be consistent with national standards, as applicable.

37 (g) A Hospital Discharge Abstract Data Record that includes
38 all of the following:

39 (1) Date of birth.

40 (2) Sex.

- 1 (3) Race.
- 2 (4) ZIP Code.
- 3 (5) Preferred language spoken.
- 4 (6) Patient social security number, if it is contained in the
- 5 patient's medical record.
- 6 (7) Prehospital care and resuscitation, if any, including all of
- 7 the following:
 - 8 (A) "Do not resuscitate" (DNR) order on admission.
 - 9 (B) "Do not resuscitate" (DNR) order after admission.
- 10 (8) Admission date.
- 11 (9) Source of admission.
- 12 (10) Type of admission.
- 13 (11) Discharge date.
- 14 (12) Principal diagnosis and whether the condition was present
- 15 on admission.
- 16 (13) Other diagnoses and whether the conditions were present
- 17 on admission.
- 18 (14) External causes of morbidity and whether present on
- 19 admission.
- 20 (15) Principal procedure and date.
- 21 (16) Other procedures and dates.
- 22 (17) Total charges.
- 23 (18) Disposition of patient.
- 24 (19) Expected source of payment.
- 25 (20) Elements added pursuant to Section 128738.
- 26 (h) It is the intent of the Legislature that the patient's rights of
- 27 confidentiality shall not be violated in any manner. Patient social
- 28 security numbers and other data elements that the office believes
- 29 could be used to determine the identity of an individual patient
- 30 shall be exempt from the disclosure requirements of the California
- 31 Public Records Act (Chapter 3.5 (commencing with Section 6250)
- 32 of Division 7 of Title 1 of the Government Code).
- 33 (i) A person reporting data pursuant to this section shall not be
- 34 liable for damages in an action based on the use or misuse of
- 35 patient-identifiable data that has been mailed or otherwise
- 36 transmitted to the office pursuant to the requirements of subdivision
- 37 (g).
- 38 (j) A hospital shall use coding from the International
- 39 Classification of Diseases in reporting diagnoses and procedures.

1 SEC. 5. Section 128740 of the Health and Safety Code is
2 amended to read:

3 ~~128740. (a) Commencing with the first calendar quarter of~~
4 ~~1992, the~~ *The* following summary financial and utilization data
5 shall be reported to the office by ~~each~~ *a* hospital within 45 days
6 of the end of ~~every~~ *a* calendar quarter. Adjusted reports reflecting
7 changes as a result of audited financial statements may be filed
8 within four months of the close of the hospital's fiscal or calendar
9 year. The quarterly summary financial and utilization data shall
10 conform to the uniform description of accounts as contained in the
11 Accounting and Reporting Manual for California Hospitals and
12 shall include all of the following:

- 13 (1) Number of licensed beds.
- 14 (2) Average number of available beds.
- 15 (3) Average number of staffed beds.
- 16 (4) Number of discharges.
- 17 (5) Number of inpatient days.
- 18 (6) Number of outpatient visits.
- 19 (7) Total operating expenses.
- 20 (8) Total inpatient gross revenues by payer, including Medicare,
21 Medi-Cal, county indigent programs, other third parties, and other
22 payers.
- 23 (9) Total outpatient gross revenues by payer, including
24 Medicare, Medi-Cal, county indigent programs, other third parties,
25 and other payers.
- 26 (10) Deductions from revenue in total and by component,
27 including the following: Medicare contractual adjustments,
28 Medi-Cal contractual adjustments, and county indigent program
29 contractual adjustments, other contractual adjustments, bad debts,
30 charity care, restricted donations and subsidies for indigents,
31 support for clinical teaching, teaching allowances, and other
32 deductions.
- 33 (11) Total capital expenditures.
- 34 (12) Total net fixed assets.
- 35 (13) Total number of inpatient days, outpatient visits, and
36 discharges by payer, including Medicare, Medi-Cal, county
37 indigent programs, other third parties, self-pay, charity, and other
38 payers.

1 (14) Total net patient revenues by payer including Medicare,
2 Medi-Cal, county indigent programs, other third parties, and other
3 payers.

4 (15) Other operating revenue.

5 (16) Nonoperating revenue net of nonoperating expenses.

6 ~~(b) Hospitals reporting pursuant to subdivision (d) of Section~~
7 ~~128760 may provide the items in paragraphs (7), (8), (9), (10),~~
8 ~~(14), (15), and (16) of subdivision (a) on a group basis, as described~~
9 ~~in subdivision (d) of Section 128760.~~

10 (e)

11 (b) The office shall make available at cost, to any person, a hard
12 copy of any hospital report made pursuant to this section and in
13 addition to hard copies, shall make available at cost, a computer
14 tape of all reports made pursuant to this section within 105 days
15 of the end of every calendar quarter.

16 ~~(d)~~

17 (c) The office shall adopt by regulation guidelines for the
18 identification, assessment, and reporting of charity care services.
19 In establishing the guidelines, the office shall consider the
20 principles and practices recommended by professional health care
21 *healthcare* industry accounting associations for differentiating
22 between charity services and bad debts. The office shall further
23 conduct the onsite validations of health facility accounting and
24 reporting procedures and records as are necessary to assure that
25 reported data are consistent with regulatory guidelines.

26 ~~This section shall become operative January 1, 1992.~~

27 SEC. 6. Section 128760 of the Health and Safety Code is
28 amended to read:

29 128760. (a) On and after January 1, 1986, ~~those~~ *the* systems
30 of health facility accounting and auditing formerly approved by
31 the California Health Facilities Commission shall remain in full
32 force and effect for use by health ~~facilities~~ *facilities*, but shall be
33 maintained by the office.

34 (b) The office shall allow and provide, in accordance with
35 appropriate regulations, for modifications in the accounting and
36 reporting systems for use by health facilities in meeting the
37 requirements of this chapter if the modifications are necessary to
38 do any of the following:

39 (1) To correctly reflect differences in size of, provision of, or
40 payment for, services rendered by health facilities.

1 (2) To correctly reflect differences in scope, type, or method of
2 provision of, or payment for, services rendered by health facilities.

3 (3) To avoid unduly burdensome costs for those health facilities
4 in meeting the requirements of differences pursuant to paragraphs
5 (1) and (2).

6 ~~(c) Modifications to discharge data reporting requirements.~~ The
7 office shall allow and provide, in accordance with appropriate
8 regulations, for modifications to discharge data reporting format
9 and frequency requirements if these modifications will not impair
10 the office's ability to process the data or interfere with the purposes
11 of this chapter. This modification authority shall not be construed
12 to permit the office to administratively require the reporting of
13 discharge data items not specified pursuant to Section 128735.

14 ~~(d) Modifications to emergency care data reporting requirements.~~
15 The office shall allow and provide, in accordance with appropriate
16 regulations, for modifications to emergency care data reporting
17 format and frequency requirements if these modifications will not
18 impair the office's ability to process the data or interfere with the
19 purposes of this chapter. This modification authority shall not be
20 construed to permit the office to require administratively the
21 reporting of emergency care data items not specified in subdivision
22 (a) of Section 128736.

23 ~~(e) Modifications to ambulatory surgery data reporting~~
24 ~~requirements.~~ The office shall allow and provide, in accordance
25 with appropriate regulations, for modifications to ambulatory
26 surgery data reporting format and frequency requirements if these
27 modifications will not impair the office's ability to process the
28 data or interfere with the purposes of this chapter. The modification
29 authority shall not be construed to permit the office to require
30 administratively the reporting of ambulatory surgery data items
31 not specified in subdivision (a) of Section 128737.

32 ~~(f) Reporting provisions for health facilities.~~ The office shall
33 establish specific reporting provisions for health facilities that
34 receive a preponderance of their revenue from associated
35 comprehensive group practice prepayment health care service
36 plans. These health facilities shall be authorized to utilize
37 established accounting systems, and to report costs and revenues
38 in a manner that is consistent with the operating principles of these
39 plans and with generally accepted accounting principles. When
40 these health facilities are operated as units of a coordinated group

1 of health facilities under common management, they shall be
 2 authorized to report as a group rather than as individual institutions.
 3 As a group, they shall submit a consolidated income and expense
 4 statement.

5 ~~(g) Hospitals authorized to report as a group under this~~
 6 ~~subdivision may elect to file cost data reports required under the~~
 7 ~~regulations of the Social Security Administration in its~~
 8 ~~administration of Title XVIII of the federal Social Security Act in~~
 9 ~~lieu of any comparable cost reports required under Section 128735.~~
 10 However, to the extent that cost data is required from other
 11 hospitals, the cost data shall be reported for each individual
 12 institution.

13 ~~(h)~~
 14 (f) The office shall adopt comparable modifications to the
 15 financial reporting requirements of this chapter for county hospital
 16 systems consistent with the purposes of this chapter.

17 SEC. 7. Section 10181.45 of the Insurance Code is amended
 18 to read:

19 10181.45. (a) For large group health insurance policies, ~~each~~
 20 a health insurer shall file with the department the weighted average
 21 rate increase for all large group benefit designs during the 12-month
 22 period ending January 1 of the following calendar year. The
 23 average shall be weighted by the number of insureds in each large
 24 group benefit design in the insurer's large group market and
 25 adjusted to the most commonly sold large group benefit design by
 26 enrollment during the 12-month period. For the purposes of this
 27 section, the large group benefit design includes, but is not limited
 28 to, benefits such as basic ~~health care~~ *healthcare* services and
 29 prescription drugs. The large group benefit design shall not include
 30 cost sharing, including, but not limited to, deductibles, copays,
 31 and coinsurance.

32 (b) (1) A health insurer shall also submit any other information
 33 required pursuant to any regulation adopted by the department to
 34 comply with this article.

35 (2) The department shall conduct an annual public meeting
 36 regarding large group rates within four months of posting the
 37 aggregate information described in this section in order to permit
 38 a public discussion of the reasons for the changes in the rates,
 39 benefits, and cost sharing in the large group market. The meeting

1 shall be held in either the Los Angeles area or the San Francisco
2 Bay area.

3 (c) A health insurer subject to subdivision (a) shall also disclose
4 the following for the aggregate rate information for the large group
5 market submitted under this section:

6 (1) For rates effective during the 12-month period ending
7 January 1 of the following year, number and percentage of rate
8 changes reviewed by the following:

9 (A) Plan year.

10 (B) Segment type, including whether the rate is community
11 rated, in whole or in part.

12 (C) Product type.

13 (D) Number of insureds.

14 (E) The number of products sold that have materially different
15 benefits, cost sharing, or other elements of benefit design.

16 (2) For rates effective during the 12-month period ending
17 January 1 of the following year, any factors affecting the base rate,
18 and the actuarial basis for those factors, including all of the
19 following:

20 (A) Geographic region.

21 (B) Age, including age rating factors.

22 (C) Occupation.

23 (D) Industry.

24 (E) Health status factors, including, but not limited to,
25 experience and utilization.

26 (F) Employee, and employee and dependents, including a
27 description of the family composition used.

28 (G) Insureds' share of premiums.

29 (H) Insureds' cost sharing, including cost sharing for
30 prescription drugs.

31 (I) Covered benefits in addition to ~~basic health care~~ *healthcare*
32 services, as defined in Section 1345 of the Health and Safety Code,
33 and other benefits mandated under this article.

34 (J) Which market segment, if any, is fully experience rated and
35 which market segment, if any, is in part experience rated and in
36 part community rated.

37 (K) Any other factor that affects the rate that is not otherwise
38 specified.

39 (3) (A) The insurer's overall annual medical trend factor
40 assumptions for all benefits and by aggregate benefit category,

1 including hospital inpatient, hospital outpatient, physician services,
2 prescription drugs and other ancillary services, laboratory, and
3 radiology for the applicable 12-month period ending January 1 of
4 the following year. ~~A health insurer that exclusively contracts with
5 no more than two medical groups in the state to provide or arrange
6 for professional medical services for the health insurer's insureds
7 shall instead disclose the amount of its actual trend experience for
8 the prior contract year by aggregate benefit category, using benefit
9 categories, to the maximum extent possible, that are the same or
10 similar to those used by other insurers.~~

11 (B) The amount of the projected trend separately attributable
12 to the use of services, price inflation, and fees and risk for annual
13 policy trends by aggregate benefit category, including hospital
14 inpatient, hospital outpatient, physician services, prescription drugs
15 and other ancillary services, laboratory, and radiology. ~~A health
16 insurer that exclusively contracts with no more than two medical
17 groups in the state to provide or arrange for professional medical
18 services for the insureds shall instead disclose the amount of its
19 actual trend experience for the prior contract year by aggregate
20 benefit category, using benefit categories that are, to the maximum
21 extent possible, the same or similar to those used by other insurers.~~

22 (C) A comparison of the aggregate per insured per month costs
23 and rate of changes over the last five years for each of the
24 following:

- 25 (i) Premiums.
- 26 (ii) Claims costs, if any.
- 27 (iii) Administrative expenses.
- 28 (iv) Taxes and fees.

29 (D) Any changes in insured cost sharing over the prior year
30 associated with the submitted rate information, including both of
31 the following:

32 (i) Actual copays, coinsurance, deductibles, annual out of pocket
33 maximums, and any other cost sharing by the benefit categories
34 determined by the department.

35 (ii) Any aggregate changes in insured cost sharing over the prior
36 years as measured by the weighted average actuarial value,
37 weighted by the number of insureds.

38 (E) Any changes in insured benefits over the prior year,
39 including a description of benefits added or eliminated as well as

1 any aggregate changes as measured as a percentage of the aggregate
2 claims costs, listed by the categories determined by the department.

3 (F) Any cost containment and quality improvement efforts made
4 since the insurer's prior year's information pursuant to this section
5 for the same category of health insurer. To the extent possible, the
6 insurer shall describe any significant new ~~health care~~ *healthcare*
7 cost containment and quality improvement efforts and provide an
8 estimate of potential savings together with an estimated cost or
9 savings for the projection period.

10 (G) The number of products covered by the information that
11 incurred the excise tax paid by the health insurer.

12 (4) (A) For covered prescription generic drugs excluding
13 specialty generic drugs, prescription brand name drugs excluding
14 specialty drugs, and prescription brand name and generic specialty
15 drugs dispensed at a pharmacy, network pharmacy, or mail order
16 pharmacy for outpatient use, all of the following shall be disclosed:

17 (i) The percentage of the premium attributable to prescription
18 drug costs for the prior year for each category of prescription drugs
19 as defined in this subparagraph.

20 (ii) The year-over-year increase, as a percentage, in per-member,
21 per-month total health insurer spending for each category of
22 prescription drugs as defined in this subparagraph.

23 (iii) The year-over-year increase in per-member, per-month
24 costs for drug prices compared to other components of the ~~health~~
25 *healthcare* premium.

26 (iv) The specialty tier formulary list.

27 (B) The insurer shall include the percentage of the premium
28 attributable to prescription drugs administered in a doctor's office
29 that are covered under the medical benefit as separate from the
30 pharmacy benefit, if available.

31 (C) (i) The insurer shall include information on its use of a
32 pharmacy benefit manager, if any, including which components
33 of the prescription drug coverage described in subparagraphs (A)
34 and (B) are managed by the pharmacy benefit manager.

35 (ii) The insurer shall also include the name or names of the
36 pharmacy benefit manager, or managers if the insurer uses more
37 than one.

38 (d) The information required pursuant to this section shall be
39 submitted to the department on or before October 1, 2016, and on

1 or before October 1 annually thereafter. Information submitted
2 pursuant to this section is subject to Section 10181.7.

3 (e) For the purposes of this section, a “specialty drug” is one
4 that exceeds the threshold for a specialty drug under the Medicare
5 Part D program (Medicare Prescription Drug, Improvement, and
6 Modernization Act of 2003 (Public Law 108-173)).

7 SEC. 8. No reimbursement is required by this act pursuant to
8 Section 6 of Article XIII B of the California Constitution because
9 the only costs that may be incurred by a local agency or school
10 district will be incurred because this act creates a new crime or
11 infraction, eliminates a crime or infraction, or changes the penalty
12 for a crime or infraction, within the meaning of Section 17556 of
13 the Government Code, or changes the definition of a crime within
14 the meaning of Section 6 of Article XIII B of the California
15 Constitution.